

Submission to the Senate Inquiry

About this submission

My name is Marianna Nugent. I am the mother of Lieutenant Max Nugent, one of the two pilots killed in the MRH-90 Taipan crash in the Whitsundays during Exercise Talisman Sabre on 28 July 2023. I make this submission as a parent of a soldier who was dedicated to his profession and who was killed while performing duties for his employer at the time, the Australian Defence Force.

Summary of key issues and requests

- Clarify how airworthiness decisions were made for the MRH-90 platform and for the TopOwl (v5.1) upgrade, including what testing was required, what testing occurred, and why contrary internal recommendations were not followed.
- Assess Army Aviation's compliance with Defence Aviation Safety Regulations, with particular focus on fatigue risk management in 6th Aviation Regiment during the lead-up to and conduct of Exercise Talisman Sabre.
- Examine Comcare's findings and the decision-making process that resulted in no prosecution under the Work Health and Safety Act, despite Comcare obtaining advice that prosecution was available.
- Review the independence, timeliness, and coordination of investigations (DFSB, Comcare, IGADF and any other bodies), including potential conflicts of interest and the lack of produced risk assessments.
- Improve family support and transparency after a fatal Defence aviation incident, including timely notification of inquiries and a clearer pathway for families to receive updates.

Personal statement

On 28 July 2023, Max was exactly where he wanted to be. After years of training, he had achieved a career goal: to serve as a Special Operations Pilot with the 6th Aviation Regiment. He was excited to be part of Exercise Talisman Sabre with his mates, putting his skills to the test and doing what he loved.

Sadly that night will always be remembered as a tragedy for our family and for everyone who knew and loved Max.

We miss him every day. Twenty-four years was not long enough to see his smile, to feel his hugs, or to share in his incredible life. The hole this has left will never be filled, but we will keep living for him, trying to find joy, happiness and peace.

We are incredibly proud of Max's service.

1. Airworthiness assessments of the MRH-90 platform and associated equipment

Much has been said about the appropriateness of the MRH-90 helicopter for use within the Australian Army. The choice of platform was controversial from the outset. It was not the Army's preferred option; the Army's preference was to update to the latest version of the Black Hawk. Instead, the Australian Government selected an unproven platform (the MRH-90), with a justification at the time that it could be assembled and maintained in Australia, creating high-tech Australian jobs.

In selecting the MRH-90, Defence was provided a helicopter system that was, in the Army's own words, "immature".

Because of this immaturity, the MRH-90 never achieved a stable, full operational capability. It reportedly flew far fewer hours than planned each year due to maintenance issues and limited parts availability, resulting in persistent unserviceability.

Reduced flying hours meant pilots and crew flew significantly less over time, which risks a compounding impact on proficiency and experience across the workforce.

A report prepared by Sir Angus Houston recommended that the MRH-90 **not** be put into the special operations role because it was not suitable for the operational tasks expected. I understand this recommendation was not adopted, and the MRH-90 was allocated to the 6th Aviation Regiment for Special Operations—consistent with the mission Max was flying on the night of the crash.

Parts availability appears to have been an enduring issue. As a relatively new aircraft type with a limited global user base, there were fewer established supply chains and fewer opportunities to draw on legacy parts.

TopOwl is a helmet-mounted display system intended to assist pilots by projecting instrument information onto the visor while also enabling night vision capability. My understanding is that it was an add-on system rather than essential for basic flight operations (for example, New Zealand does not use TopOwl on its NH90 fleet).

TopOwl (version 5.1) is equipment that, based on evidence provided during IGADF hearings, may not have been tested and introduced in a way that matched the operational conditions in which it was intended to be used. Evidence heard included claims that:

- TopOwl was not tested to the standard required by relevant authorities before being put into service.
- Army Aviation Test and Evaluation Section (AATES) identified an error associated with a software upgrade that, in their assessment, could lead to controlled flight into terrain and recommended it not be put into service; however, that recommendation was not adopted.
- When test results did not support introducing the system, testing was repeated using different pilots, including pilots who were not qualified test pilots.
- Testing did not sufficiently replicate the intended operating conditions (night flying, higher speed, close formation, and low-level flight).

2. Army Aviation compliance with the Defence Aviation Safety Regulations

Fatigue risk — Defence Flight Safety Bureau material identified the 6th Aviation Regiment as a fatigued workforce. Annual survey results reportedly reflected this, but it is not clear that fatigue risk was adequately controlled or reduced.

Fatigue was compounded by increasing workload, including administrative tasks (rostering, pay issues, and other compliance and reporting tasks). This reduced time available for core duties—training and flying—potentially worsening proficiency and increasing fatigue.

As Max said: “Army aviation runs on caffeine.”

3. Findings of the Comcare investigation

Comcare found that fatigue was an issue and that it was known within 6th Aviation Regiment, but it was not appropriately considered during planning for Exercise Talisman Sabre.

It is also my understanding that no Work Health and Safety (WHS) risk assessment was produced (or, if one existed, it has not been provided) in relation to key hazards relevant to this incident, including the MRH-90 platform, TopOwl, Exercise Talisman Sabre, the mission profile, and fatigue.

Comcare reportedly obtained independent evidence and expert input and, after completing its investigation, submitted its findings for review by Senior Counsel. I understand Senior Counsel advised there was sufficient evidence to support prosecution of the Commonwealth and potentially individuals for breaches of the Work Health and Safety Act, including in relation to fatigue management and the equipment provided to aircrew (TopOwl).

I understand this view was not adopted by the Commonwealth Director of Public Prosecutions (CDPP), and no prosecution proceeded on the basis that a successful prosecution was unlikely.

This is difficult to accept in light of the Defence Flight Safety Bureau (Dfsb) report, which stated:

“The investigation found that BSMN 83 AC (Aircraft Captain) and CP (Co-pilot) were likely experiencing a level of fatigue shown to impede optimal performance and increase susceptibility to Type 1 (Unrecognised) SD (Spatial Disorientation). The estimated level of fatigue of BSMN 83’s AC was considered sufficient to affect their actions and decisions in the event sequence.”

In my view, it was in the public interest for any WHS prosecution supported by the evidence to be tested in open court. Families of the deceased soldiers deserve transparent accountability processes, not outcomes confined to internal or government-endorsed inquiries.

By not proceeding to prosecution, the decision has undermined public confidence and has contributed to perceptions of a lack of transparency. I ask the Committee to examine the basis for that decision and what information was considered.

4. Other investigations into the incident

There have been significant delays in the release of key reports (including the Dfsb report), which then delayed Comcare reporting and, in turn, the IGADF process. I ask the Committee to examine the causes of these delays, whether they were avoidable, and what impact they had on transparency and accountability.

I also ask for clarity about which agency held authority to conduct the initial search and investigation, and how responsibilities were allocated between Defence and Queensland Police.

The Dfsb report concluded it was unlikely that TopOwl contributed to the crash. I remain concerned about the independence of that conclusion if an investigator involved in the crash investigation also had prior involvement in the recommendation to introduce the TopOwl software upgrade despite AATES advice not to. The Committee should consider whether conflict-of-interest controls were adequate and whether the investigation process met expectations of impartiality.

I understand Army Aviation was unable to provide the IGADF with any WHS risk assessment relating to the TopOwl software update. The Committee should examine why such documentation was not created, retained or produced.

5. Appropriateness of the decision not to prosecute

I ask the Committee to examine how the CDDP decision was reached, including what evidence and legal advice were considered, and why the matter was not progressed to a court process where those issues could be tested. If the CDDP concluded a prosecution was unlikely to succeed, I ask that the reasons be clearly explained to families and the public.

6. Other related matters

- Public acknowledgement at the Australian War Memorial. Currently there is no plaque for the names of those who died during training exercises. Their names deserve to be there
- Support services for parents and siblings following a fatal Defence aviation incident. There are several charity organisations for support for spouses and children – and rightly so. And we do not want to take anything away from this. However, as Max was so young, he did not have time to find his own chosen family – we were his family. To then have no recognition or support offered is really hard
- Death certificate process: our Defence certificate was received around 10 months before the Queensland Coroner's certificate. We were later told there was “no evidence” of Max's death because no remains were recovered. I ask the Committee to consider whether procedures and inter-agency coordination need improvement to avoid retraumatising families.
- Post-incident and continuing notifications: there should be a clearer and more reliable process for informing families about investigations and inquiries. We learned about the Senate inquiry through a relative. The Committee should clarify who holds responsibility for keeping families informed.
- We have received amazing support and care from North Bondi RSL. They have honoured Max's (and the other boys) life and service to their country. They have welcomed us as a grieving family and given us a safe place to be with the other families and our friends to grieve and celebrate his life. They are the only ones from Defence who seem to care and think about us.
- We did receive support from Defence in the weeks preceding the accident – through a bereavement support team and others. However, due to posting cycles within Defence, people move on from these roles. So, if we want any updates who do we contact? Max's friends have kept us informed about memorials etc, but again, they get posted out and move to different jobs. 6AVN, as his last posting, should have a liaison person or ... to keep us informed or invite us to any memorials.

Conclusion

Max and his fellow crew members deserved the safest systems, the strongest safety culture, and robust oversight. I respectfully ask the Committee to use this inquiry to identify what went wrong, ensure accountability where appropriate, and recommend concrete reforms so that other Defence families do not experience a similar loss.

Every decision matters. Throughout all the days of evidence we sat through during the IGADF inquiry, one thing has constantly come to the fore and that is decisions matter. The decisions you make may not matter today, they may not matter tomorrow, but in the moment when things go wrong those decisions do matter. People are the Defence's greatest asset – they are not just numbers or names on a page.

Thank you

Marianna, Dan and Sami Nugent